Supreme Court, U.S.
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No. 95-110

In The

Supreme Court of the United States

October Term, 1995

RYE PSYCHIATRIC HOSPITAL CENTER, INC.,

Petitioner,

vs.

DONNA E. SHALALA, Secretary, United States Department of Health and Human Services,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

REPLY BRIEF FOR PETITIONER

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FURTHER REASONS FOR GRANTING THE WRIT

As an initial matter, we note that respondent's question presented for review bears little relationship to the questions presented by the Petition. It assumes an answer to other than the question actually presented, to wit: whether the Social Security Act requires DSA payments to qualifying TEFRA hospitals, and, instead, refers to the statute and regulations pertinent only to the prospective payment system.

Respondent deals in a footnote with one of the more persistent fallacies surrounding the DSA and the one on which the court below justified the disparate treatment of providing the adjustment to PPS hospitals, but not those reimbursed by TEFRA (Brief in Opposition 15 n.7).

As the Court of Appeals put it, the PPS system pays per illness, with the payment determined on the basis of national or regional averages for treatment of that illness. PPS hospitals treating a disproportionate number of low-income patients would be shortchanged unless the per illness reimbursement were adjusted upward to take account of that fact (Pet. App. 23a).

Next, the court contrasted a TEFRA hospital whose reimbursement is based on allowable costs in its base year (albeit as long ago as 1982). These costs would include those associated with the treatment of low-income patients in the base year. As long as the proportion of low-income patients does not increase over what it was in the base year, the hospital does not sustain any extra costs not accounted for in the base year.

The obvious flaw in this analysis is that the DRG per-illness payments would similarly include the increased costs of treating low-income patients. Necessarily, the development of "national and regional averages" included significant numbers of low-

income patients on a hospital specific basis for such hospitals' base years, too. Theoretically, the DSA is no more necessary for PPS hospitals than for those reimbursed under TEFRA. Indeed, if the spectre of overreimbursement posited by the court below had any merit, Congress would not have included the DSA in TEFRA in the first place.

Congress added the DSA in 1982 to ensure that the additional costs of treating significant numbers of the poor or elderly (also included in TEFRA subparagraph (a)(2)(B)) did not go unreimbursed because such costs were not then specifically provided for in the "reasonable cost" 223 limits of section 1395x(v)(1)(A) in 1972 (Pub L. 92-603), and those of section 1395ww(a)(1)(A) of TEFRA 1982). In 1982, Congress was sufficiently impressed with the need to provide for reimbursement of such costs, which are only actuarially measurable, that it specified the adjustment for psychiatric and other hospitals and included all of those beneficiaries entitled to hospital benefits under Medicare 42 U.S.C. § 1395ww(a)(2)(B).

Respondent argues that congressional specificity in this regard no longer matters because when Congress prematurely terminated the subparagraph (a)(1)(A) rate of increase limits, the requirement to provide exemptions, exceptions, and adjustments to such limitation became inoperative (Brief in Opposition 11).

But all subparagraph (D) did was to make the specific numeric limitations of subparagraph (A) inapplicable after October 1, 1983. No one has suggested that the reasonable cost limits of section 1395x(v)(1)(A) do not continue to this day. Thus, in the absence of any hint from Congress that the need for the DSA had ended, the exception and adjustment provisions of subparagraph (a)(2)(B) remain necessary to effectuate the congressional purpose of providing payments beyond those limits.

Indeed, the legislative history is to the contrary as described in the Petition at 19-20. Moreover, the inclusion of 1984 of a DSA requirement (two years before the DSA was added for PPS hospitals) as a component of "fair compensation" for low-income beneficiaries in section 1395f(b)(2), pursuant to the entire section 1395ww, reflects continuing recognition of the importance of the adjustment.

Respondent asserts that section 1395f(b) "has been substantially modified by the TEFRA reimbursement provisions of section 1395ww(b)" (Brief in Opposition 12). In support, respondent cites the provisions of section 1395f(b) (amount of payment is "subject to the provisions of sections 1395e and 1395ww of this title") and section 1395ww(b) (applies "[n]otwithstanding section 1395f(b) of this title").

However, the language making section 1395f(b) "subject to the provision of section 1395e and 1395ww of this title" was enacted in 1982 one year *before* TEFRA subparagraph a(1)(D) made subparagraph a(1) inoperative. Moreover, respondent ignores the fact that the lesser of reasonable cost or customary charges provision of section 1395f(b)(1) would prohibit the bonus payments provided in the target methodology of section 1395ww(b). Thus, the "[n]otwithstanding section 1395f(b)" language was necessary to allow that system to operate. If Congress had intended to displace the "fair compensation" principles of section 1395f(b)(2) it would simply have repealed subparagraph (b)(1) of section 1395f. Instead, it added the DSA provision to paragraph (b)(2) in 1984.

The Secretary further argues that even if the DSA provisions of section 1395ww(a)(2) were applicable to the cost reporting periods at issue here, the Hospital still would not be entitled to the adjustment because it is discretionary with the Secretary. It is in this connection that an understanding of the Secretary's hostility

to the DSA is essential. We described the history of this hostility in some detail in the Petition at 11-15 and shall not repeat it here. The initial phrase of section 1395ww(a)(2) is mandatory — "The Secretary *shall* provide" (emphasis added). In 1982 Congress had no reason to suspect that this direction would be ignored. Congress reasonably expected that the Secretary would follow instructions and define a DSH and develop an appropriate payment methodology. The Secretary neither followed those instructions for TEFRA hospitals nor for the subsequent PPS facilities.

There is some irony in the Secretary's use of her lengthy failure to follow the congressional mandate as evidence of discretion in the matter. As the court found in *Redbud Hosp. District v. Heckler,* 1984 WL 2857*9 (N.D. Cal. July 30, 1984), the Secretary was not given discretion to decide whether to implement the congressional directive, only how best to do so.

We agree that section 1395ww(a)(2)(B) "does not imply a categorical determination that psychiatric hospitals serve large numbers of low-income patients." (Brief in Opposition 13). But it surely does constitute categorical determinations both that those that do are entitled to additional compensation for doing so, and that low-income Medicare patients generally are entitled to Part A DSA payments made on their behalf.

Apparently recognizing the fallacy in the distinction made by the court below between the "medical" and "financial" conditions of patients as the basis for denial of the DSA as a part of case mix, respondent asserts that a hospital treating a disproportionate number of poorer, thus sicker patients may obtain "meaningful relief" through section 1395ww(b)(4)(A), as interpreted by the Secretary, by applying for an adjustment ("case mix" or otherwise).

However, whether the Hospital should be at all sanguine about the prospects for such an application, the fact is that Congress intended the DSA to account for the additional costs of treating poorer, sicker patients without an expensive, time-consuming administrative process as the Secretary has agreed should be done by fiscal intermediaries for PPS hospitals. 51 Fed. Reg. 31,457 (1986).

A further flaw in the Secretary's argument is that the exemption, exception and adjustment process of section 1395ww(b)(4)(A) has not applied to PPS hospitals after 1984, *Hillsborough County Hosp. Auth. v. Shalala*, 49 F.3d 1516 (11th Cir. 1995); *Episcopal Hosp. v. Shalala*, 994 F.2d 879, 884 (D.C. Cir. 1993), *cert. denied*, 114 S. Ct. 876 (1994); *Sacred Heart Medical Center v. Sullivan*, 958 F.2d 537, 550 (3rd Cir. 1992). Since the section applies only to TEFRA hospitals, "changes in case mix" must be viewed in light of the meaning of the term given by the district court for such hospitals which, in effect, have a single DRG, *e.g.*, mental illness. A change in the mix of such cases would occur if a larger number of mentally ill poor patients were present, as Congress determined would be the case if any Hospital treated a significant number of poor patients. Because the first sentence of section 1395ww(b)(4)(A) is mandatory, the Secretary must provide an adjustment for this phenomenon. As the district court found, this is accomplished through the DSA mechanism.

Respectfully submitted,

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